New England Deaconess Hospital

pulse

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Creating a balance between the quality and quantity of life for women with breast cancer

"Uncertainty is what defeats a breast cancer patient. Everyone has statistics, but when it comes down to the individual patient, you can't translate the numbers into anything meaningful. The woman can only do what she thinks is right for herself . . ."
(an NEDH chemotherapy nurse).

Alleviating that uncertainty through comprehensive treatment and human concern is the common goal of NEDH medical and support staff members. The purpose of any breast cancer treatment is to prevent local recurrence and spread of the disease with as little damage to normal cells and tissue as possible.

Sometimes the objective of improving survival rates conflicts with other psychological and cosmetic priorities of a woman with breast cancer. Maintaining a balance between the quantity and quality of life has been made easier in recent years with continuous innovations in surgical and radiotherapeutic techniques, and research in chemotherapy and hormone manipulation. In this, the concluding installment of a two-part series on breast cancer, PULSE will examine the treatment options available to a woman with breast cancer.

* * * *

Ten years ago, treatment alternatives for a woman with breast cancer were limited. She went into the hospital for a biopsy and, if the tumor was found to be malignant, she underwent a **radical mastectomy*** while still under anesthesia for the biopsy. The woman would awake from surgery to discover her diagnosis, and the loss of her breast, at the same time.

Until fairly recently, the radical mastectomy was considered to be the best method of treatment, since it was thought that cancer cells spread in a definite progression from the breast, to the axillary **lymph nodes,** then through the bloodstream. By removing the breast immediately upon finding a malignant tumor, surgeons believed that they could prevent metastases (spread of cancer) as well as local recurrence.

But some doctors began to experiment with lesser surgery when they came to realize that they were getting no improvement in their patients' survival rates despite ever more extensive surgery. Results from these efforts led a consensus conference of breast cancer specialists, endorsed by the National Institutes of Health (NIH) in 1979, to recommend the **modified (or total) mastectomy** as the standard mode of treatment for **"early" breast cancers.**

The NIH conference also recommended the "two-step" biopsy. A delay between biopsy and treatment gives a physician time to make additional tests for metastases if necessary, but more importantly, it provides adequate time for a patient and her physician to discuss treatment options. The two-step procedure also allows for more accurate **"staging"** of the tumor.

Alternative to Mastectomy

Some women with operable breast cancer have chosen an alternative treatment in order to preserve their breast.

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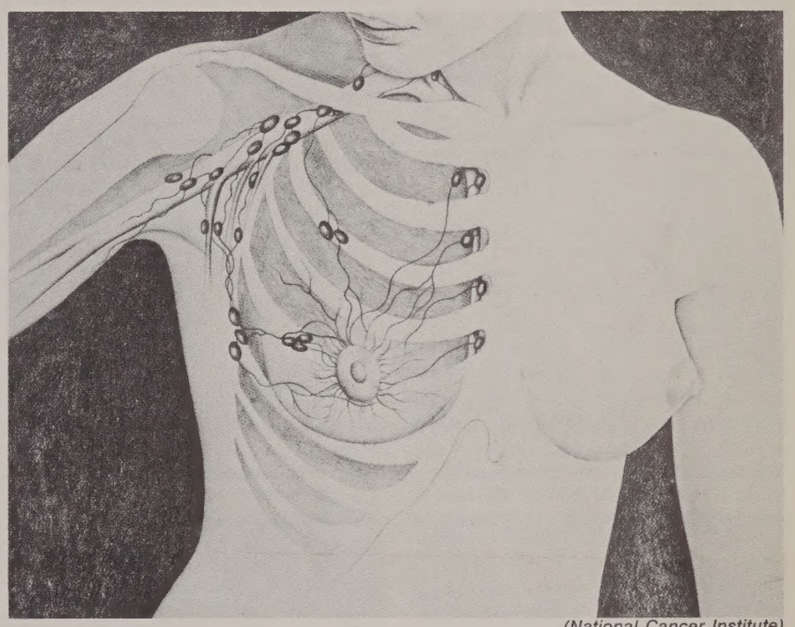


(National Cancer Institute)

Lymph nodes are small knots of tissue located adjacent to the breast, under the arms (axillary) and behind the breastbone (internal mammary lymph nodes). The lymph nodes are connected to the lymphatic system which transmits fluid from the body's immune system and collects bacteria removed from body tissues.

**Words or phrases printed in boldface are defined in the glossary on page 2.*

School of Nursing holds 83rd graduation exercises

The NEDH School of Nursing held its 83rd graduation exercises on June 11 at Temple Israel in Boston. Marvin G. Schorr, chairman of the NEDH Board of Trustees, presented diplomas to 44 graduates from greater Boston and New England who completed a three-year nursing education program.

Sister Mary Robert Nagle, S.C., R.N., M.Ed., director of the School of Nursing at St. Vincent's Hospital and Medical Center, New York City, delivered the graduation address which focused on the changing role of nurses as professional health care providers. Sister Mary Robert is also a member of the Governing Council Assembly of Hospital Schools of Nursing for the American Hospital Association.

Greetings from the NEDH medical staff were delivered by Dr. Frank C. Wheelock, Jr., chief of the NEDH vascular surgery division. The message from the graduating class was given by Martha J. Crowinshield. Graduate Donna Linger received the annual alumnae scholarship which was presented by Mrs. Lois Schutz, president of the NEDH School of Nursing Alumnae Association.

Earlier in the day, baccalaureate and pinning ceremonies were held at the Daniel Marsh Chapel, Boston University. Reverend Cecil Breton of Gordon College, Wenham, was the guest speaker at the ceremonies.

(more photos on page 3)

Beatriz Maria Alfonso (r), Class of '76, presents a bouquet of flowers to Cynthia Erskine, highest honors recipient.

FRIENDS DEDICATE BAKER ROOFTOP GARDEN — *Lois Krall, president of the Friends of the Deaconess, addresses a gathering at the May 19 dedication ceremony of a new rooftop garden for patients and family members. Located on top of the Baker building, the garden was designed and built by the hospital's maintenance and engineering department with funds provided by the Friends of the Deaconess. The garden offers patients and their family members a quiet, sunny spot outside of the hospital to talk or read in privacy.*

NEDH support staff provides care throughout therapy process

Breast Cancer *(continued from page 1)*

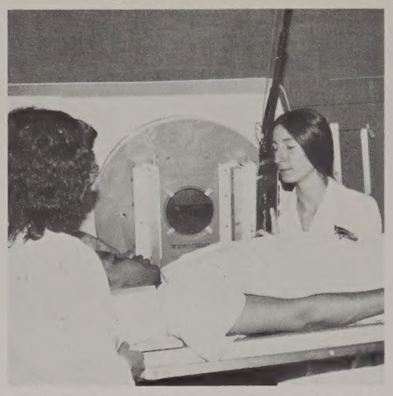
Instead of mastectomy, they have elected to undergo a lumpectomy (removal of the cancerous lump) followed by radiation therapy.

Dr. Blake Cady, a surgical oncologist, finds that the ten-year survival rates of lumpectomy/radiation therapy patients is comparable with those of modified mastectomy patients in the treatment of tumors less than 2 centimeters (cm) in diameter. "But the reason women may prefer lumpectomy/radiation therapy is not because it is better cancer treatment, but because of cosmetic and psychological considerations," said Dr. Cady. "Radiation therapy is no less radical a form of treatment than surgery. Occasional patients may over respond to radiation treatment and, of course, its effectiveness depends upon the skill of radiotherapists in planning treatment and the quality of equipment used. And we don't know what tissue effects radiotherapy may have on a woman 15 to 20 years from now. On the basis of 10-year statistics, we do know that lumpectomy/radiation therapy patients have a higher local recurrence rate," he continued.

"No one in the country knows what breast cancer treatment will be considered 'standard' five years from now because the field is changing so rapidly and so many new developments are appearing. Over the years, we've been able to do less extensive local surgery. In the future, maybe we can do less aggressive radiotherapy as well in order to achieve the same results," he said.

Improved diagnostic techniques, resulting in earlier detection of breast cancer, have encouraged the use of lumpectomy/radiotherapy as primary treatment. The procedure was pioneered at the Joint Center for Radiation Therapy (JCRT), which includes the Deaconess and six other Harvard teaching hospitals, by Dr. Samuel Hellman, JCRT director, and his associates. More than 550 women have been treated by lumpectomy/radiotherapy at JCRT since 1968 including nearly 400 since early 1978.

Karen Erickson, R.N., oncology team leader.



JCRT Technician Donna Paci (r) and student technician Anita Mendes.

Margaret O'Connell, oncology social worker.

"Traditionally, mastectomy has been the accepted form of **local/regional treatment,** providing tumor control in that area in 85-90% of the cases," said Dr. Jay R. Harris, NEDH radiotherapist. "Results from further studies showed that total mastectomy combined with postoperative radiation was equivalent to radical mastectomy in local/regional control. The next step was to see if radiation could be combined with even more conservative surgery and still achieve the same results," he continued. "This approach of conservative surgery for resection of gross cancer, combined with moderate dose radiation to the breast and draining lymph node regions is what is meant by primary radiation therapy for breast cancer," Dr. Harris explained. JCRT staff members stress that primary radiation therapy is a reasonable alternative to radical surgery when adequate surgical and radiotherapeutic expertise is available to deliver this treatment.

American clinical trials comparing modified mastectomy and **segmental mastectomy**/radiotherapy have not been in progress long enough to produce meaningful results. However, foreign clinical trials have shown evidence of the effectiveness of conservative therapy. In an article published in the New England Journal of Medicine earlier this month, researchers from Italy's National Cancer Institute reported their findings from a clinical trial which compared radical mastectomy to **quadrantectomy**/radiotherapy. The 701 patients involved in the study were assigned randomly to the treatments and followed for up to 7 ½ years. There was no difference in the two groups in terms of survival or recurrence of the disease.

"Out of 176 lumpectomy/ radiotherapy patients treated from 1968-77 at JCRT, 5-year actuarial survivals are 94% for Stage I and 73% for Stage II tumors," said Dr. John T. Chaffey, director of the NEDH division of the JCRT. "These results are comparable to those seen following mastectomy in similarly staged patients. Local failure has been acceptably low so far, and since most local/regional recurrences develop within three years of treatment, we don't anticipate significant increases after a longer follow-up period. Radiation treatment side-effects are tolerable and the final cosmetic result has been rated good to excellent by 88% of the patients," Dr. Chaffey noted. Concern has been expressed that radiation therapy itself will cause new tumors, but Drs. Chaffey and Harris agree that no study has shown that therapeutically applied radiation induces a significant incidence of new cancers.

Two women currently undergoing radiotherapy at JCRT represent the "best" candidates for lumpectomy/radiotherapy – tumors less than 2 cm with no evidence of tumor in the axillary lymph nodes.

One woman, "Maureen", went to her doctor because of an inflamation in her left breast. A mammogram revealed that the inflamation was easily treatable, but it also detected an abnormality in her right breast. The non-palable lump was malignant, and Maureen, 32, selected lumpectomy/radiotherapy. "I have a very supportive family who pushed me to get all the information I could even before the biopsy," said Maureen. "But no matter how much information you have, you still feel so vulnerable, so easily swayed by anyone. You have to have your mind set on what you want to do from the very beginning. I decided if it was a choice between mastectomy and my life, I'd choose mastectomy," she explained.

"Losing a breast is an awful thing – our society places so much emphasis on the breast as a symbol of a woman's femininity. But is it any worse than losing another part of your body, such as an arm or a leg, to disease?" Maureen elected to have a lumpectomy followed by 4 weeks of daily radiation treatment to the tumor area. The precise dose and treatment area is determined by a staff of radiotherapists, radiological physicists, biologists and computer experts.

Following these treatments, Maureen was admitted to the Deaconess for three days to receive a booster dose of radiation through an iridium implant in the tumor site which is designed to destroy any remaining cancer cells. Tiny plastic tubes are inserted horizontally through the breast and radioactive seeds are placed in the tubes and left in place for 50-60 hours. The iridium is encapsulated and will not contaminate other people, and there is no residual radiation left in the patient when the implant is removed.

"Elizabeth", 54, had fibrocystic disease, a disorder which caused her breast tissue to be lumpy, so she had been carefully checking her breasts for years. Her physician had made a chart of where the benign lumps in her breasts were located so she would be able to note any changes. "Several months ago, I noticed one of the lumps was different – it hadn't changed size or shape, yet I felt something was wrong," said Elizabeth. A biopsy revealed that the lump was malignant. Elizabeth's first reaction was to have a mastectomy. "I wanted to be rid of the cancerous part of my body and get on with life. I felt my body had betrayed me. Throughout my entire life, I had been careful to diet, exercise and get an adequate amount of sleep. I had been

(continued on page 4)

Glossary

Adjuvant chemotherapy – Use of anti-cancer drugs immediately after surgery in cases where there are signs that the woman is at high risk for developing a recurrence of the disease.

"Early" breast cancers – Generally classified as tumors two centimeters or less in diameter with no sign of tumor in the axillary lymph nodes.

Local/regional treatment – Treatment of the breast, chest wall and draining lymph node areas, either by surgery, radiation therapy, or a combination of both.

Lymph nodes (see illustration, page 1) – Small, oval-shaped glands which act as way stations for the lymph capillaries that drain the tissue sections of the breast. Axillary lymph nodes are located in the armpit.

Modified (or total) mastectomy – Removal of the breast, some fat and most of the axillary lymph nodes. The pectoral (chest) muscles are left intact, helping to preserve the contour of the chest wall.

Quadrantectomy – Removal of the quadrant of the breast containing the tumor, plus the axillary lymph nodes.

Radical mastectomy – Removal of the breast, covering skin, pectoral muscles, all lymph nodes and fat.

Segmental mastectomy – Removal of the tumor plus a wedge of normal tissues surrounding it, including some overlying skin and part of the pectoral muscle lining under the tumor.

"Staging" – Staging of the tumor is determined by its size, the extent of lymph node involvement and whether or not the tumor has spread to distant organs. Stage I tumors are less than 2 centimeters (cm) in diameter with no evidence of metastases or palpable lymph node involvement. In Stage II disease, the tumor is between 2 and 5 cm in diameter with or without palpable lymph nodes thought to contain cancer, with no evidence of distant metastases; Stage III includes tumors larger than 5 cm with or without clinically positive lymph nodes, but no evidence of distant metastases.

Graduation day highlights for the School of Nursing

Honors went to: (front row, l-r) Barbara Gomes, Susan Powers, Lisa Zitso, Cynthia Lupu; (second row, l-r) Mary Keane, Cheryl Hamilton, Donna Linger, Lori Maarshalk; (third row, l-r) Jean Hollingshead, Virginia Umland, Wendy McGee, William Murphy; (fourth row, l-r) Carolyn Knapp, Maureen Hooper, Jean Hildebrand, Claire Boissel; (fifth row, l-r) Penny Vasilas, Thomas Mahoney, Celeste Rene.

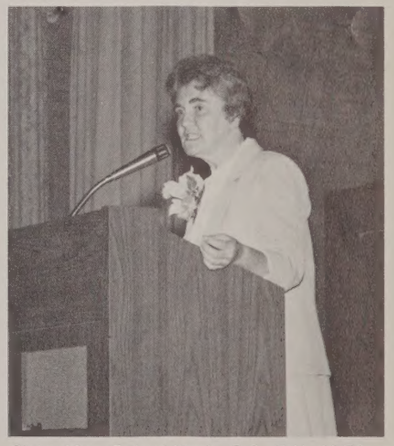
Graduates staying at NEDH are: (front row, l-r) Barbara Gomes, Susan Powers, Lisa Zitso, Cynthia Lupu, Carolyn Cain, Debra Bryant; (second row, l-r) Martha Crowninshield, Mary Keane, Donna Linger, Bonnie Shepard, Marlene Smith, Cynthia Erskine; (third row, l-r) Virginia Umland, Linda Knopp, Jean Hilderbrand, Wendy McGee, William Murphy; (fourth row, l-r) Jean Hollingshead, Dianne Richards, Carolyn Knapp, Maureen Hooper, Elizabeth Hampe.

Martha Crowninshield delivers the message from the graduating class to an audience which included (l-r): Marvin G. Schorr, NEDH President Laurens MacLure, NEDH Director of Nursing Ellen D. Howland, Dr. Frank C. Wheelock, Jr., and Sister Mary Robert Nagle, R.N.

Donna Linger receives the nursing alumnae scholarship from Mrs. Lois Schulz, president of the NEDH School of Nursing Alumnae Association.

Director of the School of Nursing Ellen D. Howland pins members of the graduating class at the baccalaureate and pinning ceremony.

Ellen D. Howland receives a check for the School of Nursing scholarship fund from Lois Krall, president of the Friends of the Deaconess.



Sister Mary Robert Nagle, S.C., R.N., M.Ed., a member of the Governing Council Assembly of Hospital Schools of Nursing for the American Hospital Association, delivers the address to the graduating class.

Virginia Umland receives her diploma from Marvin G. Schorr, chairman of the Deaconess Board of Trustees.

Class officers were: Dianne Richards, treasurer; Wendy McGee vice-president; Martha Crowninshield, secretary; Donna Linger, president.

Attention SON Alumnae

Alumnae Day will be held Saturday, November 7. Watch for more details in the next issue of PULSE.

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Nancy Seideman, Editor

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Breast Cancer

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good to my body, and to get cancer in return . . ." Several of her friends urged her to seek other options, and Elizabeth eventually selected lumpectomy/radiotherapy, even though she had a great fear of radiation. "I had to keep telling myself that I had to treat my immediate problem, and not worry about what radiation treatment might do to me 10-15 years from now," she said. Both Maureen and Elizabeth had high praise for the JCRT nurses and technicians. The nurses explain to patients how to care for their skin during treatment, and how to deal with other possible side-effects from radiotherapy and the iridium implant. The nurses assess the patients' needs during therapy and sometimes refer them to the NEDH dietary or social service departments. "They all treat you like a special person," said Elizabeth. "They're never too busy to answer your questions, and they always answer your phone calls promptly. And when you're on the treatment table, the technicians have respect for your vulnerability and treat you with dignity."

Once local/regional therapy is delivered, physicians continue to monitor a patient for signs of metastases. One of the best indications of whether or not cancer has spread is by taking a sampling of the axillary lymph nodes when the tumor is biopsied. If the nodes show no evidence of tumor involvement, then the woman's prognosis is considered to be better, since the sampling indicates that the cancer probably has not spread. If lymph nodes contain tumor, then **adjuvant chemotherapy** may be used in addition to surgery or radiotherapy.

"Until recently, chemotherapy wasn't used until cancer had spread," explained Dr. Jacob J. Lokich, chief of the NEDH Medical Oncology Section. "But studies have found that beginning adjuvant chemotherapy for high-risk women immediately after surgery can postpone or prevent a reccurence, especially in premenopausal women," Dr. Lokich said. Chemotherapy involves the use of potent drugs, singly or in varying combinations, to destroy cancer cells as they divide. Although the drugs also damage normal cells, their value in improving survival rates of breast cancer patients has been proven. Deaconess breast cancer patients receive the latest data on chemotherapy drugs through the hospital's participation in national clinical drug trials.

Each drug acts in a specific way, and has its own individual side-effects, so all women receiving chemotherapy must be monitored carefully. When a patient visits the Deaconess Oncology Unit to see her physician and receive treatment, she also is seen by one of four chemotherapy nurses. Led by Karen Erickson, R.N., the nurses teach patients and their families the side-effects produced by the anticancer drugs and by pain medications.

Breast Consultation Service

Finding the right doctor for the "right" treatment is a time consuming and confusing process for a woman who has just been told that she has breast cancer. The fact that doctors disagree on different modes of treatment, and that there are no individual breast cancer specialists trained in all phases of treatment, both add to a woman's predicament.

In an effort to bring specialists together to better advise women in any stage of breast cancer treatment, from diagnosis to breast reconstruction, the Deaconess has established a Breast Consultation Service (BCS). As outlined in the May/June issue of PULSE, the BCS has five specific goals: optimal care through a multidisciplinary approach to treatment; early screening for women with high risk of developing the disease; a second medical opinion for women seeking a confirmation of diagnosis; counsel at decision points along a patient's course of therapy; breast reconstruction services.

The possibility of breast reconstruction following surgery can provide a psychological boost to women who choose mastectomy. The modified mastectomy preserves the pectoral muscles, making reconstruction easier and more cosmetically pleasing. "The criteria for successful breast reconstruction is how a woman appears in clothing, not nude," explained Dr. Francis Wolfort, an NEDH plastic and reconstructive surgeon.

"The breast mound is restored by placing an implant under the skin and a pectoral muscle," said Dr. Wolfort. "A benefit of the multidisciplinary approach to breast cancer treatment has been the fact that we are often consulted before primary treatment begins if a woman has decided on reconstruction after mastectomy. In this case, her surgeon can place the incisions in a different location with reconstruction in mind without compromising treatment."

A woman visiting the BCS receives evaluations and information from a full medical team – radiotherapist, surgeon and medical oncologist – all in one visit. A woman can refer herself to the BCS by calling the Deaconess Oncology Unit (732-8438), or her own personal physician can arrange the consultation for her.

Dr. Chaffey, who, along with other medical staff members is volunteering his time to the BCS, feels it is beneficial for physicians to see a patient at the same time. "We can get a better idea of the woman's attitude, and what treatment she feels more secure with," he said. "A physician has the responsibility to take most of the burden of a decision from the patient."

Elizabeth agrees with this view. "I didn't feel qualified to make a decision of that magnitude alone. Fortunately, my cancer was discovered early and I had a choice. But I wanted my doctor's confirmation that he would tell me if he thought I was making a mistake," she said.

NEDH medical and support staff members are available to provide professional expertise, not only in the delivery of care, but also in supporting a woman throughout her therapy process so that she does not feel alone. "We try to ease her anxiety during this uncertain period in her life by giving her the tools to take control again," said Margaret O'Connell, NEDH oncology social worker. "She is a person who happens to have breast cancer. We must help her to regain confidence in her body, to marshal her resources, including the encouragement of family and friends, so she can deal with her disease, then get on with living."

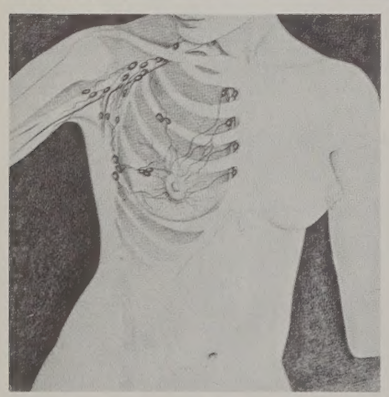
Deaconess News in Brief

Thompson Greenlaw assumed his responsibilities as manager of the NEDH Building Services Department on April 13. For the past three years, Mr. Greenlaw served as director of environmental/safety services at the Cape Cod Hospital. He was director of housekeeping and linen services at Nashua Memorial Hospital, New Hampshire, from 1976-78, and executive housekeeper for Glover Memorial Hospital, from 1975-76.

Christine Murray, director of dietetic internships, has been named one of three "Recognized Young Dietitians" in 1980 by the Massachusetts Dietetic Association. The award, which will be presented at the association's annual meeting this fall, was given in recognition of Ms. Murray's accomplishments in clinical nutrition, education and research.

Ms. Murray also co-authored a chapter on "Enteral Nutrition of the Hospitalized Child," and compiled the appendix, in the recently published "Textbook of Pediatric Nutrition" (R. Suskind, ed).

A biography of **Margaret A. Burns,** R.N., director of the surgical services department, has been included in the "Who's Who of American Women" (12th edition, 1981-1982). The selection was made by the Marquis Publications Board which chooses individuals who have "demonstrated outstanding achievement in their own fields of endeavor, and who have thereby contributed significantly to the betterment of contemporary society."



Improving the quality and quantity of life for women with breast cancer *(see page 1)*

School of Nursing holds 83rd graduation *(see pages 1 and 3)*

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